Out-of-Hospital Protocols
January 6, 2009 Discussion

PURPOSE
To outline the **dispatch protocol** for all time critical diagnosis patients.

PROTOCOL (draft used for discussion)	**Changes at meeting**
1. All agencies who accept calls for EMS assistance from the public and/or dispatch emergency medical personnel shall be certified and have an Emergency Medical Dispatch Priority Reference System (EMDPRS) used by certified Emergency Medical Dispatchers.	1. All agencies who dispatch emergency medical personnel shall be certified and have an Emergency Medical Dispatch Reference System (EMDPRS) used by certified Emergency Medical Dispatchers.
2. All EMDPRS protocols used by emergency medical dispatch agencies must be approved by the EMS Service Medical Director to assure compliance with national standards. Any EMDPRS approved by the EMS Service, including its questions, instructions, codes, and protocols, shall be used as a whole rather than piecemeal.	2. All EMDPRS protocols used by emergency medical dispatch agencies must be approved by the EMS Service Medical Director to assure compliance with national standards. Any EMDPRS approved by the EMD medical director including its questions, instructions, codes, and protocols, shall be used as a whole rather than piecemeal.(need to include both)
3. Use of a Department-approved EMDPRS on every request for medical assistance.	
4. Each EMD shall follow the questions and decision-making processes within their EMDPRS in compliance to the written policies and procedures of their EMD agency as approved by the EMS Service.	
5. Each EMD shall provide dispatch life support (including pre-arrival instructions) in compliance to the written text or scripts and other processes within the approved EMDPRS.	
6. Each EMD agency shall have in place EMS Service approved policies and procedures for the safe and effective use of their approved EMDPRS.	
7. Need to add QI	

DISTRIBUTION All Pre-hospital Operations Personnel.	
PURPOSE To outline the **treatment guidelines** regarding patients experiencing a suspected stroke.	
PROTOCOL (draft protocol used for discussion)	**Changes made at Dec. 2 meeting**
ON SCENE	
1. ABC's (follow Airway/Oxygenation Protocol). Maintain oxygen saturation at a minimum of 93%. If oxygen saturation falls below 93%, administer low flow oxygen at 2-4 LPM.	1. ABC's (follow Airway/Oxygenation Protocol). Maintain oxygen saturation at a minimum of 93%. If oxygen saturation falls below 93%, administer low flow oxygen at 2-4 LPM. (more specific) Do not routinely administer high flow oxygen to stroke patients. **IF** the patient has shortness of breath, oxygen saturation below 92%; or decreased level of consciousness, increase oxygen as needed.
2. Obtain blood glucose level. Treat only if less than 50 mg/dl.	2. Obtain blood glucose level. Treat only if less than 50 mg/dl.
Obtain vital signs and a brief history. (NOTE: Make sure to include last time without symptoms and any additional witness information).	2. Obtain vital signs and a brief history (last time seen normal or without symptoms.
3. Perform a basic stroke exam using the Cincinnati Prehospital Stroke Scale (?).	3. Perform a basic stroke exam using the Cincinnati Prehospital Stroke Scale. need state standard - single, universal don't specify which one easy to remember stroke group: LA includes age, more info don't lock into Cincinnati
4. Do not delay transport. If the patient does not have an immediate life threat, transport urgently to a stroke center if available (within 10 minutes when possible).	4. Do not delay transport. Transport urgently to a stroke center (on scene time of 10 minutes or less). Determine the most appropriate means of transport, for example air.

Treatment Guideline PROTOCOL, continued (draft protocol used for discussion)	Changes made at Dec. 2 meeting

NOTE: A stroke center as defined by TCD regulation. Level ? if < ? minutes Level ? if > ? minutes but < ? minutes	stroke: need to regionalize less than two hours of symptom onset - any facility with tPA (nearest level I, II, or III) hospital has 1 hour to treat treatment needs to start within three hours if longer, need to identify regionally if system onset cannot be determined, take to highest level available if not tPA eligible, need to go to primary care for neurologist to evaluate suggestions- make this regional goal is three hours - regional decision how to meet three hour goal - timeline needs to be revised as new evidence comes in
EN ROUTE	
1. Contact Medical Control and notify of possible stroke patient as soon as possible.	1. Contact receiving facility and notify of suspected stroke patient as soon as possible.
2. Obtain vital signs and EKG.	
3. Establish an IV (follow IV Protocol).	3. Establish an IV (follow local IV Protocol). IV should be large bore at least 18 gauge
4. Perform an expanded stroke exam if time and patient condition will allow.	4. Additional exam en route (beyond Cincinnati) other screening tools
5. Do not treat hypertension without specific approval from Medical Control.	
6. Patient should be transported with head elevated less than 30 degrees, unless risk of aspiration is present.	6. Patient should be transported with head flat unless risk of aspiration is present. -Need reference from stroke group
7. Patient handoff at the hospital should include: patient assessment and condition upon arrival, including time of onset; care provided; and changes in condition following treatment.	Stroke group – family contact - cell number where family can be contacted immediately medications need from stroke group: inter-hospital transfer protocol